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lanning Council

Prioritization and Evaluation and Assessment Committees

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REFERENCE BOOK

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mbers Present at Meeting:

Maria Ramos
Kirsten Balano
Mary Jane Wood
Tom Sinclair
Brett VanBenschoten

taff:

Michelle Long Dixon
Louis Sands
Celia Cantou

check-in on 8/4 council meeting
prioritize mental health, substance abuse and case management service categories
plan the 8/11 prioritization meeting
discuss the retreat on 8/23

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yor's HIV Health Services Planning Council

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Calvanese
Reynolds
Carter
e Jones
y Joe
Goudey
Maria Ramos
Kirsten Balano
Mary Jane Wood
Tom Sinclair
Brett VanBenschoten

S Office Staff:

n Klain
Martinez
Zellers
Morowitz
Michelle Long Dixon
Louis Sands
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Office, told her the results would be presented 8/18. *WC* said that *BP* told him that would happen 8/11. *JKl* noted the importance of the council having a clear sense of the definition of "severe need". *DJ* said that there seams to be more of a consensus about that this year than last, but of course there should still be a common definition for all to use. *Jim Illig*, of Project Open Hand, asked *JKl* to distribute the definition of "severe need" according to HRSA.

Prioritization of the Mental Health Service Category:

DJ recapped the 7/31 prioritization meeting and suggested beginning this week's discussion with the mental health treatment service category. She reviewed that the focus for prioritization is to serve the most severe need, which the committee defined last week as the uninsured and underinsured homeless with the highest severity of illness. The co-morbidities outlined at this meeting included housing status, substance abuse, mental illness, with special consideration given to the unique needs of women, undocumented immigrants and the incarcerated population. *MLD* reported that the AIDS Office staff present has discussed and compiled that office's information and recommendations relating to each of the service categories, which will be presented at this meeting.

Where the Money Went in 1996: *WC* distributed a handout of information about the use of 1996 CARE funding to the mental health category. He explained that the bulk of the funding went to licensed psychotherapy, followed by psychiatric consultations, crisis services, mental health case management and residential care. The licensed psychotherapy category, which mostly serves individuals on a short-term basis, includes counseling for HIV+ women and programs at UCSF AIDS Health Project. *RZ* added that the licensed psychotherapy category contains two large programs; one which is a mental health case management program that blends individual work and case management, and the other is a multi-diagnosis program. Both these programs serve PWAs with severe need. *TC* asked, in reference to the handout, why the CMHS contract for Westside Chateau showed 0 units of service, yet has an invoiced amount. *RZ* explained that the Westside Chateau is a housing facility for chronically mentally ill patients with and without HIV. The facility burned down two years ago, but has now been rebuilt such that it can be occupied, and now CARE is obligated by contract to resume payments for occupancy expenses and a portion of the program itself. Although the facility is not yet accepting clients, CARE money is being used to pay property tax etc. *TC* asked the number of beds at the facility, and how many will be devoted to HIV+ patients. *RZ* replied that there are fifteen beds, half of which are for PWAs. *TC* observed that CARE should not pay the entire occupancy fee if not all patients are PWAs, and requested reference of this issue to the Evaluation and Assessment Committee.

AIDS Office Staff Recommendations: (See handout) *RZ* reported that the staff felt that the severely and chronically mentally ill benefit most from intensive case management, pharmaceuticals, and crisis services, and less from traditional psychotherapy. It was also agreed that a one-stop shopping model would best serve this population because it provides easy access to services. Also discussed was the possible need for a locked facility for people with severe dementia. *TC* asked about St. Mary's, to which *CC* responded that that facility has a two-week time limit. *TC* said that is not true. *RZ* further reported that service gaps were discussed, including services for women with children, family services for youth and intensive case management for multi-diagnosed PWAs. *Laura Feren*, Director of the Medically Indigent Adult program at the Family Services Agency, asked how the AIDS Office staff generated the above list of services needed by the chronically mentally ill. *MLD* explained that the list was born out of discussions of the seventeen service categories, using the observations and knowledge of the staff. *Jim Dilly*, Executive Director of the AIDS Health Project, expressed agreement with the Aids Office staff's opinion that this population benefits only moderately from inside therapy. *Laura Feren* requested the definition of "brief therapy". *CC* explained that

n sessions or less constitutes brief therapy. *WC* asked for some examples of pharmaceuticals for the severely hronically mentally ill. *Jim Dilly* explained that they include medications for chronic and severe anxiety, cinations etc. *WC* asked why these drugs are not included in outpatient ambulatory care pharmaceuticals. *JKI* ined that the difference is the point of access to care. *RZ* said that the outpatient ambulatory care naceuticals category covers some psychoactive drugs, such as antidepressants, but the bulk of psychiatric cations which are distributed through the mental health system are paid for out of General Fund, not CARE. *Feren* reported that according to the Pharmaceutical and Therapeutic Committee, which monitors the drug cations for DMS, psychiatric medications will continue to be paid for out of the pharmacy. *DJ* asked if the ittee is clear that psych. medications are not funded within the mental health category. (Yes, the committee is . She further asked if the committee wished to propose that that be changed. *CC* responded that while that part not change, there needs to be a strong support system surrounding the medications to ensure that patients are fully supported in terms of medication monitoring, evaluation and adherence. *KB* said that the interaction of AIDS medications with psychological medications creates an even stronger need for integration of services. *MM* to at some point open a discussion of how protease inhibitors are effecting mental health services, and if it is ble at this point to determine needs which will arise in the coming year.

ration of Services: *MJW* recommended identifying the integrative service system. She said that San Mateo has a system, and it works well but costs a lot of money, time and energy for relatively few units of service. ams may not be willing to adopt such a system. *DJ* observed that providing services to a high-need population tly, but it is probably more cost-effecient to do it in one integrated program than many separate ones, with ate administrative expenses. *TC* observed that the discussion of integration seems to include two different : integration of CARE-funded services for primary care, mental health and substance abuse, and integration other funding streams. He agreed with *MJW* that a solely CARE-funded integrated system for multi-diagnosed s will not work. The task here should be to get a sense of the relationship between the mental health providers provide pharmaceuticals, and CARE mental health providers which serve clients *after* receival of medication. e does the responsibility of the prescribing provider end, and that of the CARE-funded case manager or mental service provider begin? Without an understanding of that relationship the council can not have a meaningful sion of service integration.

ders Speak: *DJ* reviewed the two issues on the table: the effect of protease inhibitors on mental health services, tegration of services. *JKI* asked the providers present to talk about the services they provide to the CARE target ation.

Feren said that the new treatments have resulted in increased referrals due to increased hope. Many people are ng about their lives and health in terms of the long-term for the first time, which motivates them to seek es. In the case of mental health services there is a greater demand for psychotherapy, neuroleptics and naceuticals.

illy explained that his organization runs a substance abuse case management program, where almost all patients fered protease inhibitors but few accept them, mainly due to the feeling that the drug regimen is too icated. Thus, he is not seeing much impact of the new drugs in this population. In the psychotherapy am, however, one of the main changes revolves around support groups. People who have been supporting each through the same trials for years, and are now finding that their friends are getting better due to new treatments they are not, have whole new issues to deal with.

Eileen Bulger, psychiatric nurse in the AIDS Health Project, described a patient she has been working with for years, who has multiple physical and mental health problems. This patient was *greatly* helped by an integrated system, and although integration is costly it was probably less costly than the alternatives for this person would have been. She said that members of this population need a safe place to go, where they will have access to registered nurses, case managers etc., and this program needs to be coordinated with the city.

WC observed that the CARE target population is the patient who *Eileen Bulger* described, and that this population is not cost efficient, and is easy to push aside as a difficult and frustrating group to serve. Regarding a safe harbor for members of this population: which piece of this integrated project should CARE be responsible for? *Eileen Bulger* said that the population of multi-diagnosed PWAs who are leaving prisons is in dire need of CARE support because if they are not hooked into services quickly they end up back in prison.

Laura Feren noted that although not all of the Community Mental Health clients fit the criteria of the CARE target population, there are also many who do. She said that integration can also mean a concerted effort not to duplicate services which are already available elsewhere. *RR*, CARE Council member and Larkin Street Youth Center case manager, said that the one-stop shopping model which is employed at his agency is very effective. The city's mental health program, CHIPS etc. do not seem to work, and if Larkin Street's clients relied on that system none of them would be on antiretroviral medications, whereas with Larkin Street's system roughly 80% of the clients are taking these medications. This system includes an on-site psychiatrist, who is not full time and therefor not overly costly, who will go *to* the clients when necessary. *RR* further stated that without CARE funding this program would not be possible.

TC said that Larkin Street Youth Center has the right idea, and the discussion of integration does not include a discussion of what categories to cut, but of how to better direct money within categories. He also asked what percentage of people in the mental health system are HIV+, and what criteria would exclude a PWA from accessing the mental health system? The people who are excluded from the system should be part of the target population. Also, how can CARE dollars be used to augment the existing mental health system? The CARE Council and its supporters need to move to change the city's system now, while CARE has the power to do so, because if the city's system has not improved when the CARE Act is finished then people will be stuck with a system that does not respond to the needs of PWAs. *LS* asked if any document exists which shows the fate of PWAs with respect to the mental health system before CARE money became available. *Jim Dilly* responded that there is no specific document, but from his experience he would say that before the CARE Act PWAs received very little mental health care, and that which was received was often very poor. In terms of integrating services, the system right now is not able to pass clients from one program to another according to their individually changing needs, due to service gaps, long waiting lists etc. This needs to be changed to create a continuum of care.

BVB asked *Jim Dilly* and *Eileen Bulger*, who work with the city's mental health system, if it would be possible to use the work they do with the system as a starting place for building linkages. *Eileen Bulger* noted that there already are a few good collaboration efforts in progress. *RZ* said that the problem is not the CMHS's unwillingness to serve people who fit the CARE funding criteria, but the restrictiveness of the city's funding, which forces the system to serve only the most severely mentally ill clients. Thus, the clients who do not fit into that category have no support other than CARE.

Laura Feren said that the Medically Indigent Adult program has managed to form links with CMHS, which primarily take the form of time-limited treatments, at the end of which some go to OMI clinics, if they fit certain criteria. By

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g into Community Mental Health these clients are ensured long-term care, which keeps them in treatment. *Jim* agreed that it is possible to get clients into CMHS, but this sets up a revolving door.

s Munz, of CMHS, agreed that the system is set up to only serve a very narrow window of clients.

id the task of the council is to make the existing services more responsive to PWAs. He agreed with *TC* that 's time and money is running out, and it must be used to affect long-term change in the system which will when CARE money is gone. *MM* observed that there should thought given to the "not quite as needy" tion, because without help they become the neediest very quickly.

itization of the Substance Abuse Service Category:

viewed the AIDS Office staff recommendations from the packet that was distributed (see packet). The nce abuse treatment service system has increased its capacity for PWAs in the past few years, so now the task is rmine the specific needs of PWAs in this system. *BVB* observed that many of the issues which are outlined in cket are repetitive issues for PWAs with substance abuse problems.

itization of the Case Management Service Category:

eviewed the AIDS Office staff recommendations from the packet (see packet). *Jim Illig* expressed the opinion e AIDS Office staff has the best perspective on how disjointed the service system is, and these mendations are ways that the CARE Council can help the AIDS Office coordinate AIDS care with the rest of partment of Public Health. This should be the role of the Planning Council, which has the legal right to tell its es exactly how to prioritize their HIV+ clients. *DJ* said that the council can direct and facilitate, but not te.

id that, regarding case management, the first issue which needs to be addressed is the structure of the system, in everyone gets a case manager whether needed or not. The council must identify who needs case management st, and ensure that they are the first to get it. The second issue is that the case management system needs to e mobile by including something like the "roving team" which was included in the five-year plan. *Eileen* noted that Continuum has a mobile case management program. *TC* said that the role of peers in the system also be discussed. Peers form a natural system of helpers, which is still untapped by the case management . The use of this population is stated as a goal in the five-year plan, and has not even begun. He also sed the opinion that the gatekeeping model which is stated as a goal in the five-year plan is outmoded and l be re-evaluated. *TS* sited the Bridge Project as an innovative, mobile care system which the council should ne and learn from.

said that *Jim Illig* was correct in the idea that the AIDS Office is looking for ways to work with the city's health to coordinate AIDS care with the rest of the DPH. She also raised the issue of volunteerism, and how the spirit unteerism is being effected by new AIDS treatments and the subsequent increase in health. *MM* noted that case ers are lowest on the care totem pole, and need to be made equal with other providers in the decision-making s. *RR* observed that the idea which *TC* and *WC* expressed regarding long-term changes in the existing system e sounds good in theory, but would not meet immediate needs, which still need to be met while the long-term es are being researched and implemented.

August 11 Prioritization Meeting

JKI distributed and explained three funding scenarios - dollar breakdowns, which do not include the HOPWA rollover. These scenarios are, level funding, small cut and large cut. At the 8/11 prioritization meeting the committee needs to decide how to present these scenarios to the council. It is likely that CARE will get less than level funding. This year there is a 1% reduction in the formula, which is a set amount of about $18 million. Supplemental funding is unknown. She suggested prioritizing according to scenario one (level funding), and then using that prioritization as a baseline for the various possible percentage cuts. *WC* observed that the council must specify the services which are essential and can not be cut even if it means cutting more from other services. *TC* said that prioritization discussions need to focus on criteria, need, indicators of severe need and the need for particular services within each category, and only *after* that has all been hashed out should the discussion turn to actual allocations. He expressed concern that the prioritization will degenerate into something resembling the model used last year, and said that the only way to fully avoid that is to get into a zero-based budgeting mentality.

KB suggested that committee members try to work out the prioritization on their own and bring ideas to the meeting on 8/11. *TC* recommended that everyone look at the five-year plan which Marcy developed as a place to begin the process. *DJ* reviewed the homework for the 8/11 meeting: review the AIDS Office staff handout, study the document provided by WC and read the five-year plan. She noted that a breakdown of what is included in the $2.7 million HOPWA rollover is needed in order to decide if the council will accept it. *WC* asked the AIDS Office staff to provide the HOPWA information with as much detail (UOS etc.) as possible.

The Mayor's HIV Health Services Planning Council meets on the third and fourth Mondays of each month, at 10 United Nations Plaza, 6th floor. The next Steering Committee meeting will be held on May 12, at 25 Van Ness Avenue. All are welcome and have the opportunity to comment on Agenda items. The site is fully accessible and assistive hearing devices and signing are provided upon adequate notice to the Council. Minutes of meetings and all information distributed to Council members are available for inspection and copying. For further information, contact the Council's staff, 553-9135. For requests for excised documents, Emily Cole at 771-3229. *Minutes of meetings are tentative until formally approved by the council.*

Mayor's HIV Health Services Planning Council

August 11, 1997

Minutes of Prioritization and Evaluation and Assessment Committees

Council Members Present at Meeting:

Tom Calvanese
Don Reynolds
Bill Carter
Diane Jones
Danny Joe
Gene Goudey
Kirsten Balano
Mary Jane Wood
Laura Thomas
Tomy Leone
Steve Lew

Support Center Staff:

Maria Ramos
Jade Kaye

AIDS Office Staff:

Judith Klain
Lisa Martinez
Miss Zellers
Mark Morowitz
Billy Pick
Marcia Herring
Jim Piland
Michelle Long Dixon
Louis Sands
Celinda Cantu
Cari Deloa
Walta DeLemos
Delia Garcia

Agenda items:

DJ distributed the agenda, which is modeled off of the council meeting agenda format. She explained that the prioritization discussion will include the three funding scenarios to be presented by *JKl*. *DJ* also announced that *Tom Leclair* will not be able to attend this meeting. *MR* announced that she has a synthesis of the small group reports to present at this meeting. *JI* asked why public comment was limited to ten minutes, to which *DJ* replied that it is an effort to allow as much time for the committee members to discuss the prioritization and formulate proposals, since time is very limited at this point. *JI* expressed the opinion that having these meetings open to the public has worked well, and he has objections the limitation of public input, but understands the reasoning.

AIDS Office Staff Prioritization Recommendations:

DLD distributed a handout of AIDS Office staff prioritization recommendations for the seventeen CARE funded service categories. She explained that this handout is the product of several meetings held by the AIDS Office staff, and listed several reasons for this re-evaluation of service categories: 1. many of the contracts are several years old and may not reflect changing needs in the community, 2. because program managers are the primary persons who deal with contractors, they have a unique viewpoint on services, 3. program managers need to share their experiences across service categories in order to help contractors create linkages. The recommendations which resulted from these discussions reflect the knowledge of many people, including contractors from all the service categories. Many of the ideas presented have not been analyzed in terms of cost, timeline etc., but can be at the request of this committee. In addition, many of the changes suggested can be made internally through contract negotiations and clarification of contract language. Some suggestions would require increased funding to certain categories, and some require only redirection of funding. (See handout).

AIDS Office Staff Recommendation Questions and Discussion:

Food service: *MJW* expressed the opinion that vouchers instead of food bags would be problematic because people will sell them, or use them to buy a small amount of food and get change for the remaining amount.

Outpatient/Ambulatory Care/Dental: Regarding the perceived need to augment youth-specific primary care servic *TM* observed that due to the low UOS number (67%), for youth services, these services should be re-examined before their funding is increased. *RR* noted that 67% UOS is a combined number from youth services, and some programs (s as Larkin Street Youth Center), are well above that number. Therefor it is important to examine individual programs. *DJ* said that she sees more and more youth using the ER as a primary care provider.

Housing: *WC* requested the amount of money in HOPWA in the coming year. *LT* said that HOPWA is getting level funding, which will be about $11 million. *BP* said that the CARE Council should re-examine its relationship with HOPWA because CARE absorbs the HOPWA rollover every year. *WC* explained that the past two community input meetings have made it clear that a continuum needs to be created between housing, home care and hospice, such that people can move between these different services as needed. He requested the AIDS Office's ideas on this issue. *ML* explained that the system needs to change so that hospice can be a temporary place where people can go to recover, without losing their previous housing. *WC* asked how a person's previous residence can be held for them if they need extended hospice stay. *MLD* said that if the Prioritization Committee requests further analysis of this suggestion the AIDS Office will look into the specifics of its implementation.

Case Management: *MJW* observed that many of the recommendations (especially those related to case management) rely on a much more centralized system than is currently in place. She asked what was the discussion on this issue. *MLD* replied that the case management recommendations were developed with the assumption that this is a 3-5 year plan, to be implemented through incremental changes. The institution of REGI is also expected to provide the kind of client tracking which would be necessary for a primary case management system. *RZ* explained that one of the issues case management is client duplication, which could also be decreased with the institution of REGI.

Transportation: Regarding the concern that some cab companies refuse service to and from certain areas, *DJ* commented that the contract which SF General has with Luxor Cab Co. requires that service be provided regardless of location. The system is, however, difficult to monitor.

Buddy Companion: *DJ* asked if the definition of this service category allows payment to buddy companions, or if the need to be volunteers. *MLD* said that they can be paid. *MJW* said that in the past the Assessment Committee has questioned the cost-efficiency of funding a volunteer buddy companion program vs. paying buddy companions. *RZ* sa that it has been found to cost less to pay companions than run a volunteer program. *CC* noted that often people attend buddy companion volunteer training and then use the knowledge gained for their personal needs, and do not volunteer.

Client Advocacy: *WC* observed a growing need for return-to-work programs, which would probably fall into the clier advocacy category and should be addressed by the council.

MLD also reviewed a second handout, entitled "Program Development Unity, Service Category Planning Meeting Outcomes", which outlined systemwide new program ideas and recommendations for their implementation (see handout).

Planning Committee Report--Consensus Statement:

LT apologized that due to extenuating circumstances she was unable to complete her part of the report for today's meeting. Hers will be the section which focuses on needed changes, qualities to preserve in the system, and how the council can initiate change this year with an eye toward maintaining the system over time. She explained that the document will aim to provide the council with a context reaching back several years as well as projecting a few years into the future.

SL explained that at this point the consensus statement is actually only the ideas of a few people on the Planning Committee, but the goal is to create a statement from the council which will outline baseline, general points of consensus on the service system as it exists now. The document should examine what the council has accomplished in terms of the five-year plan and what main problems still need to be addressed. The committee will try to provide historical context on the five-year plan, the service categories, systemwide development etc., so that people understand that the plan was created in response to fragmentation of the service system. The document will also examine strengths and weaknesses of the system by summarizing recent updates on the five-year plan, client satisfaction, needs assessmer as well as ongoing council discussions such as the unmet needs of multi-diagnosed PWAs. Likely points of consensus regarding strengths are: a lot has been accomplished since the execution of the five-year plan, the council has continued to provide a continuum and to decrease need across service categories, the target population is largely being reached an

system is fairly cost-efficient. Some weaknesses to be noted in the consensus report are: integration of services tinues to be a challenge, there is still unmet need, services are still fragmented, REGI has not come on line in a way to act the entire system, and the CHIPS system still has a lot of critics, consumer participation and the planning of very services is not happening at the systems level, EMA-wide planning is lacking, and with a few exceptions there still no universal standards for providers in terms of services and client outcomes.

estions and discussion: *DJ* asked if the entire document will be ready for the full council meeting on August 18. *LT* ied that it will. *SL* explained that the hope was to have the Prioritization Committee review it first, and suggested ng the first draft to committee members as soon as possible. *DJ* asked which service categories might lend nselves to EMA-wide planning. *LT* said that *John Conley* raised the issue of EMA-wide planning around dementia, pice, late-stage care, housing issues and portability of housing vouchers. *CC* noted that, regarding the lack of dards of care, many agencies (especially in the areas of mental health and substance abuse), have generic standards ch are not specific to their HIV+ clients. The job of the council, then, is to create a system which *is* PWA-specific. noted that, although many organizations have standards, these standards often have points of contention.

luation Committee Report:

reported that the committee has been overwhelmed by the combined tasks of figuring out its role and working with AIDS Office in researching numbers. The numbers which came out of this research proved very helpful during the ic testimony meetings, and will hopefully give the council a better awareness of the impact of its prioritization sions. *MJW* added that this data has not been analyzed on purpose, so that it can be used as a tool without added mmendations or possible biases. *SL* asked if the Evaluation Committee plans to analyze the data at some point. *V* responded that it does not, except to the extent that it has already been analyzed in terms of breaking down the four ls of reporting, from general to detailed. *DJ* suggested that Evaluation and Assessment Committee members point ncil members toward applicable parts of this report during discussions, to help people who have not worked with the bers get a better grasp of how to use them and what they say. *SL* agreed that some guidance, and perhaps comments bservations by the Evaluation and Assessment Committee would be helpful.

ll Group Discussion Summaries:

reported that the Prioritization Committee needs to give council members more specific feedback on how to use the rt-back sheets, because many groups used them to ask questions rather than highlight points of consensus and ible recommendations. The following are the main points which came out of group discussions over the past five ks:

1. June 23: instead of discussing service categories and Planning Council support, small groups discussed unallocated funds. All groups suggested that this money be allocated to shallow rent subsidies and direct emergency financial assistance, which one group defined as housing, rent, utilities and medications.
2. July 14: two groups said that CARE needs to define "essential/core services". Other comments and recommendations included: allocate more money to rehabilitation, job placement and return-to-work programs; adjust hospice and home care to better reflect the changing needs of the HIV+ population; move case management priority focus toward early intervention; case management may need to include more professionals and fewer volunteers; people with substance abuse and mental health problems need more links to the system.
3. July 21: three groups reported that dental is clearly an unmet need. Three groups also reported that housing needs are also not being met. Two groups agreed that more outreach is needed for the homeless population. Another two groups agreed that women and children need better service; one of these recommended increasing funding for childcare.
4. July 28: groups asked a lot of questions. All groups commented on the need for increased coordination between service providers. One group suggested redoing RFPs after the prioritization process is completed.

Projections:

JKl distributed a handout entitled "City and County of San Francisco CARE Title I Funding and Service Levels CAR Year 08". She explained that if funding were to continue as at was in CARE year 07, including the H@PWA rollover CARE will be about $7.5 million short. With this in mind, the three scenarios are 1. 17% increase in funding 2. leve funding minus the 1% formula cut 3. 5% funding cut. In response to several questions about how these dollar amoun and percentages were generated, *JKl* explained that last year HRSA awarded CARE dollars as if for a twelve month f year, even though this EMA's year only lasted eleven months. Because the coming fiscal year is one month longer th last, but funding will not be raised accordingly, the dollar amounts look much smaller. No more detailed explanation the numbers can be given at this time. *LT* said that the AIDS @ffice needs to provide more specific data on how these dollar amounts were reached in order for the council to continue its prioritization process fully informed. *WC* disagre a general idea of the funding that can be expected is sufficient because the prioritization process needs to be driven by service needs, not the amount of money this EMA will receive. *MJW* added that, for grant-writing purposes, the cour should request a grant amount based on what it feels it should be providing, not what it expects to get. *DJ* said that th council would probably be best served by a level of information somewhere between *LT*'s and *WC*'s suggestions, because although the council should not prioritize based on the grant amount, there is a lot of anxiety around it, which could be somewhat alleviated by more specific information.

Prioritization Discussion:

DJ suggested amending the agenda to allow provider participation during this discussion, and apologized to *JI* for not notifying him of the planned public comment restriction in advance.

DJ said that this discussion should begin by focusing on broad points of consensus regarding necessary changes, and i should be noted when recommended changes may be associated with a change in funding.

Points of consensus:

1. severe need is defined as "uninsured and underinsured homeless with low socioeconomic status, with co-morbidities including substance abuse, mental health problems". *MJW* asked how "low socioeconomic stat is being defined. *RZ* further asked what is meant by substance abuse and mental health problems (what severity constitutes a problem). *DJ* asked if the committee should define those terms now. *WC* expressed t opinion that the definitions may be different for different service categories. *SL* suggested that the definitio be left general for now, but in the next step of the process can be defined more exactly for each service category. *JK* asked where co-morbidity factors fit into the discussion. *JKl* explained that they are points of unmet need which should be specifically addressed in each category. She also suggested adding African American as an area of unique need. The committee agreed to define the "need" terms separately for each category.
2. there needs to be coordination of HIV-specific services with the broader healthcare and social services delivery system (*DJ*). *WC* expressed the desire for the CARE Council to facilitate a re-integration of CARE services with those offered by other departments. By "coordination" does the committee mean that CARE should be one of the players, or does it refer to true re-integration in which cost is shared with other departments? *DJ* said that the word "integration" is commonly used in the service system, and therefor sho be used in this discussion.
3. new medications are creating changes in all service categories and causing uncertainty about the future of HIV/AIDS care (*KB*). *GG* expressed the opinion that the future is not at all unclear in terms of HIV/AIDS care. *KB* modified the statement to read: new therapies are causing rapid changes which effect service need
4. each service must include a component which links it to primary care (*WC*). Following some confusion *WC* changed "a component which links it" to "some relationship". *SL* expressed the opinion that because prima care seems to reach the most people already, people should be able to access other services *from* primary ca rather than the other way around. *WC* responded that one obstacle for many people in seeking the treatment they need for various problems is that they are told problem #1 can not be addressed until problem #2 is solved, and so on. To eliminate this approach primary care should be a central point (as stated by HRSA), from which people can move into the additional services they need. He further clarified that primary care d not mean doctors, but the HIV-specific primary care system. *TM* observed that, although San Francisco has

strong primary care system, there are still differences in care receival according to race/ethnicity, socioeconomic status etc. *TC* suggested adding "access to treatment" to the centrality of primary care services.

5. the CARE Council must give clear, detailed mandates and directives to the AIDS Office (*DJoe*).
6. the plan to be generated may take more than one year to fully implement (*WC*).

tpatient/Ambulatory Care/Dental:

noted that access to new treatments must be a priority. *TM* cited the 30% in *Dr. Bangsburg*'s study of multi-gnosed homeless who do not have access to primary care as a high need population. *WC* said that to him the highest d population in this category is the dully and triply diagnosed population, followed by those who have opportunistic ections resulting from HIV disease, and then people with ongoing primary care needs. He suggested putting people on pectrum in this category because people have different needs at different times. Income also needs to be included in spectrum of need. *DJ* noted that income testing is always involved in the issue of ADAP. She added youth to the list igh need populations because they currently have very low access. *BP* suggested that for some populations the issue ot access to treatment, but consistency in management, which should be included in this list because it often manifests lf as low utilization of services.

suggested shifting the discussion to mental health and substance abuse and their linkages to primary care. She cited Bridges Program as a model of one way to form a connection between services. *MLD* said that the word "linkages" ds to be defined more specifically. *DJoe* suggested the term "active linkages". *TM* stressed the importance of ages being measurable. *DJ* said that some primary care providers were upset by the omission of a primary care nponent from the Tenderloin Care contract. Because the program does not have contractual linkages to primary care, dependant upon the good will of providers to come in and fill that gap. This is an example of the importance of uding primary care in any contract in order to form a contractual relationship. *WC* expressed the opinion that it is the DS Office's responsibility to ensure the specifics of the relationship, and the CARE Council need only state that a age must exist. *KB* noted that links need to be two-way, so that not only are people referred to other services from nary care, but are also tracked to see if they actually access the other services, and are served by them. *TM* said that stance abuse programs have methods of measuring outcome, which could be used by other services as well.

e noted that there needs to be more interaction between case managers. *TC* suggested focusing the discussion on the ired outcomes for each category and how they can be achieved. In terms of case management, a goal is to eliminate e management for a piece of the client in favor of wholistic case management in which one primary person would be client's contact point through whom s/he accesses all needed services.

asked if the committee wants to discuss drugs or complementary therapies in relation to the primary care service gory. *WC* referred to his homework assignment, in which he assigned pharmaceuticals to their own service category handout distributed by *WC*). In this handout he also suggested carving out a portion of HIV pharmaceuticals in r to better control what and who are CARE-funded, and collecting the multiple CARE pharmacy lines into one gory. *DJ* observed that these suggestions seem contrary to the goal of integration. *WC* said that the difference is that gration under other circumstances is quantitative, whereas this is guess work. If CARE is able to track who is ered for what drugs, when they are covered and how, then fewer people will be left *un*covered. This system would make it possible to ascertain what is covered by MediCal and what by CARE. *MJW* reminded the committee that ie pharmacy contracts are for pharmacists, not drugs. And some of these pharmacists actually serve in the capacity of dication managers. *DJ* noted that some also work as case managers.

ıtal: *MJW* said that it is time to re-examine the RFP because it is clear that there are serious access problems and nveniences associated with University of the Pacific dental school. *DJ* asked how many organizations answered the inal RFP. One. *WC* suggested maintaining the U. of P. services while RFPing additional services which are not vided there, including looking at community-based practices and sliding scale programs. He noted that frequently a tist is the first to recognize a problem in an HIV+ client, thus the dentists which CARE works with must be wledgeable about the dental problems faced by PWAs. *DJoe* suggested either funding a mobile dentist unit, or a tist who rents chairs around the city in order to increase access for PWAs in different areas. *GG* said that a roving tal unit would be too expensive, but in San Mateo there is a program in which a dentist rents dental chairs in different ıs, and it has been very successful. *DJ* observed that this change may require increased funding to the dental gory. *DJoe* said that if it is a preventative measure then it may not require more money. *WC* said that this service

category needs increased funding due to documented unmet need, not due to the changes that the committee is suggesting. *GG* noted that the dental needs of some communities (especially multi-diagnosed homeless), are immens and would be very costly to meet. Thus, in order to meet the needs of these populations the funding to the dental category would have to be greatly increased. *TC* said that the cost-effectiveness of existing services should be re-examined, because it may not actually be more costly to provide services to more people if it is done in a more efficie manor.

MJW observed that the alternative and traditional therapy category within primary care did not invoice out or provide units of service, therefor perhaps excess money from these services should be redirected to other primary care service *WC* agreed that rather than increasing funding to primary care, the funding should be reorganized within the category increase cost-efficiency. *TC* suggested that the council also ponder the question of how many people who are using CARE funding for primary care services have another funding source that they are not using. He suggested that CARI initiate a program by which CARE dollars can be used for a co-pay, in a primary care subsidy, or in voucher form. Th types of aid would capture the clients who have other coverage but do not want (or can not afford) to pay the co-pay offered by insurance companies. *MJW* said that CARE money can not be used for co-pays. *TC* said that in that case th council needs to take more measures to ensure that CARE is the payer of last resort, as is written in the legislation. *M.* suggested that all CARE systems be changed over the long term to become fee-for-service. *DJ* noted that that idea run contrary to the DPH's current direction.

WC explained his process in formulating the recommendations which he distributed (homework). He addressed each category, considering for each the target population and other relevant issues. He recorded the specific considerations and challenges for each category and then made recommendations for changes and linkages that can be made within a between categories. He admonished the council members present to try this same process on their own before the nex prioritization meeting. *DJ* asked what the council will request in terms of funding for each category: more, less, level, actual amounts. *WC* recommended asking in terms of percentages rather than actual amounts. *DJ* said that there shou still be a directive in terms increase or decreased funding to specific categories, which *WC* agreed with.

Homework for the next prioritization meeting: create recommendations for the categories of outpatient/ambulatory care, housing, substance abuse, mental health, food, dental, client advocacy and case management.

JKl asked for questions about H@PWA. *Chris Terest,* of the Redevelopment Agency, reported that the H@PWA rollov for the coming year will be about $1.3 million. The amount is not exact at this point because some of the contracts contained therein are in flux. The contracts in this rollover are: Catholic Charities, Peter Claver Community, Larkin Street Community Services, Lutheran Social Services, Hazel-Betsey, Maitri and Waldenhouse. *BP* asked how much money H@PWA has in total. *Norma Thompson*, also of the Redevelopment agency, was not sure, but said that in 1997 H@PWA had $7.9 million. *WC* asked if there are $16.6 million in capital developments coming from H@PWA, and th cost per bed is around $65,000-70,000. *Norma Thompson* reported that the cost per bed ranges from $14,000 to $127,000. This difference reflects difference in location, activation cost etc.

Next Prioritization Meeting:

The committee changed the **8/18** meeting time from 11:00-1:00 to **12:00-4:00PM**, at the AIDS Office. Another meetir was scheduled for **8/19 10:00-12:00PM**. At these meetings the committee will review homework and prepare prioritization proposals to be presented at the 8/18 full council meeting, plan the retreat and address small group structu and the conflict of interest/areas of expertise issue.

The Mayor's HIV Health Services Planning Council meets on the third and fourth Mondays of each month, at 10 United Nations Plaza, 6th floor. The next Steering Committee meeting wil held on May 12, at 25 Van Ness Avenue. All are welcome and have the opportunity to comment on Agenda items. The site is fully accessible, and assistive hearing devices and signing ar provided upon adequate future notice. Minutes of meetings and all information distributed to Council members are available for inspection and copying. For further information, contact th Council's staff, 554-9136. For requests for excused absences, Emily Coles at 777-3229. *Minutes of meetings are tentative until formally approved by the council.*

ayor's HIV Health Services Planning Council

August 19, 1997

nutes of Prioritization and Evaluation and Assessment Committees

ncil Members Present at Meeting:

Calvanese, Kirsten Balano, Ron Reynolds, Rita Times, Will Carter, James Abrams, Diane Jones, Gene Goudey

S Office Staff:

th Klain, Michelle Long Dixon, Billy Pick, Celinda Cantu, Marcia Herring, Marcy Fraser

ers Present:

illig, Project Open Hand and Contractors' Association
git Lachman, German guest

nda items:

ne Jones:	*TC*'s and *WC*'s prioritization proposal to reconfigure services
	proposed new service category: direct emergency financial assistance
	allocation scenarios
	retreat agenda
	materials to be sent in the pre-retreat packet

onfiguration of Services:

utlined the main proposed reconfigurations: 1. consolidate housing, hospice and residential substance abuse and mental health ment programs within the housing category 2. move all case management into the case management category 3. combine dental primary care within the outpatient/ambulatory care category.

nary Care/Dental: The committee expressed support for the movement of dental services into the primary care category. *JKl* d the importance of ensuring that dental services receive their own funding in the prioritization process. *TC* responded that the tion is not to lump services, but to keep them as discrete, yet related, subcategories.

e Management: *DJ* explained that there are currently case management services under housing, substance abuse, mental health primary care. *KB* observed that there are specialists in this field, which should not be lost in a consolidation of case management ices. Perhaps general, one-stop shopping case management should be consolidated, and specialists placed in subcategories. *TC* mented that that issue is more detailed than necessary at this time. *KB* noted that, once lumped, it will be more difficult to rate contracts back out into subcategories. *DJ* asked if the committee could agree to ***combine case management services***, with a on *KB*'s concern. *BP* expressed support for the proposal, and warned the committee to work with the framework and not to get on the details.

sing: *JKl* raised the concern that HRSA may not allow the combination of residential treatment programs with housing, and may armed by such inflation of the housing category. *BP* observed that the category will not be so inflated if HOPWA picks up ational housing costs for residential treatment services, as proposed. In response to *JKl*'s concern regarding the allowability of ombination of services, *TC* suggested instead breaking out residential treatment programs as subcategories within substance e and mental health, in order to facilitate their linkage to housing services. *JI* expressed concern that a decision to reorganize e categories is premature, and may actually cause harm either from the standpoint of the grant proposal or the contractors. *DJ* that the category organization can not be delayed because it will determine allocations. *TC* further noted that his idea precludes mbination of services. ***The committee agreed to suggest the creation of residential treatment subcategories within substance e and mental health categories.***

patient/Ambulatory Care/Dental: *KB* expressed support for the proposal to move home health services into this category. *TC* gested rolling the proposed pharmaceuticals subcategory back into primary care and breaking out home health as a subcategory ad. ***The committee agreed to add dental and home health as subcategories within Outpatient/Ambulatory Care, and roll rmaceuticals back into primary care.*** *MF* noted that in order to qualify for home care under MediCal one must be home *bound*, n outpatient.

suggested discussing the possibility of creating a treatment advocacy subcategory within Client Advocacy to reflect recent ssions of the increasing need for this service. *KB* said that her small group at the August 18 full council meeting suggested ng treatment advocacy to the proposed pharmaceuticals subcategory within Outpatient/Ambulatory Care. *BP* noted that treatment vocacy services are currently within the client advocacy category, but some of the contracts are tied into primary care. He gested addressing the issue later. *TC* explained that the discussion of treatment advocacy involves the function and the contracted

service (two different things). It is clear from discussion that the function should become more integrated with case management, peer advocacy, buddy companion etc., but the contracted service should remain under Client Advocacy for now.

JI said that the current discussion is based on the assumption that the AIDS Office will have numbers comparing the current syster with that being proposed, in time for the retreat. This is an unsafe assumption. *DJ* replied that the question of numbers is prematu *TC* responded that the pertinent numbers are already available.

Direct Emergency Financial Assistance: *GG* asked if unallocated funds have previously been directed to AIDS Emergency Func be used for direct emergency financial assistance. *TC* replied that this service is currently funded within housing and client advoca *GG* suggested making it a subcategory of support services, rather than forming a new category. *DJ* noted that "supportive services an umbrella term which refers to several discrete categories. *WC* explained that direct emergency financial assistance was broken as a new category because it is on a list of suggested categories in the green book. *JI* noted in Marin this used to be a separate category, but was combined with primary care in order to better target those with the greatest need. *TC* proposed the creation of a ***separate direct emergency financial assistance category, under the support services umbrella.*** The committee agreed.

JKl suggested adding an outreach category, as recommended by HRSA. This would address the recent discussions of access. *TC* agreed that outreach is important and requires more attention. He said that many CARE-funded programs are contracted to do outreach, and asked how a new outreach category would relate to that which is already contracted within other services. *JKl* said tl outreach need not be a separate category, but should be kept in mind. *WC* suggested that outreach could be augmented in substanc abuse, mental health and case management. The committee agreed to leave the question of outreach for later, but flag it as an upcoming issue.

Allocation Scenarios:

DJ suggested starting the discussion with *Mary Jane Wood*'s allocation proposal, which was presented at the August 11 Prioritizati Committee meeting. *TC* noted that *MJW*'s numbers do not reflect the category changes just discussed. *DJ* proposed to revisit each category, restate its contents and have a qualitative discussion about possible funding increases and decreases of subcategories. Th committee agreed.

Outpatient/Ambulatory Care: add home health and dental, roll laboratory contract into primary care. *DJ* asked if the allocation this category should be increased if there is a 5% funding cut. *JKl* noted that the issue of ADAP funding may become important in the future. *WC* said that there may be money left over to cover emergent costs such as ADAP. *RT* suggested increasing funding to the dental category in order to enhance accessibility. *WC* suggested raising it $6,400, which would offset the amount University of the Pacific exceeded its UOS in the past year. *KB* asked *GG* what exactly CARE pays for in the dental category; salaries, equipment...? *GG* was unsure. *RR* noted that in terms of paying salaries, it may actually be more cost efficient to pay a licensed dentist than dental students, who may work more slowly and make mistakes which necessitate more visits. *GG* said that additional units of service will require more money, regardless. *RT* said the issue may be more focused on access than actual UOS. The committee decided to recommend ***increasing funding to the dental subcategory***.

MLD reported that the complimentary therapy subcategory received $22,000 more than it invoiced last year. The committee decide to suggest a ***$22,000 decrease in complimentary therapy funding***.

RT noted the possibility of decreasing home health funding due to the decreased need for home care and hospice. *JI* raised the concern that the committee is using the information provided by *WC* and *TC* to examine individual contracts, which is not the job o the CARE Council. *WC* responded that without the detailed numbers it is not possible to make informed funding decisions. *JI* said that the decisions should be made on the category level, rather than the contract level. *DJ* suggested using the numbers provided by *Russ Zellers*, of the AIDS Office, in this conversation. According to these numbers, $200,000 of the home health allocation was no spent last year. *KB* noted that there has been discussion of moving these services in the direction of skilled nursing, and away from hospice. Any cut to this subcategory should be moderate in order to allow this change. *DJ* said that concern would be better placed on the issue of hospice funding. *MLD* observed that, as presented, the home health and hospice numbers are difficult to separate. *L* expressed the opinion that even given these concerns this is an area that can be cut. *GG* observed that the demand for home infusionseems to be declining, which is another reason to cut this subcategory. He suggested cutting at least $200,000. *DJ* suggeste decreasing home health funding by $300,000. *TC* reminded the group that home health serves the sickest people, which is the CAR target population. *JA* agreed, and expressed discomfort with such a large cut. He noted that getting a person to the hospital for infusions can be exceedingly difficult. *DJ* said that she has observed in the hospital that strict criteria are not used in deciding who gets a home infusion, thus this service is not necessarily targeting the sickest. Decreasing funding may ensure that only the people with the severest need receive this expensive service.

DJ noted that time is short and the retreat agenda has yet to be discussed. She suggested that a subgroup form to finish the allocatio proposal process, using the format which was employed in the Outpatient/Ambulatory Care category discussion, and the committee now turn its attention to the retreat agenda. That idea met with strong opposition. The committee decided instead to extend this meeting to 1:00 PM. *TC* reminded the committee that in the prioritization process the target population can not be forgotten, and

gested that as the process continues the group focus on the question of severe need and which services meet it, and propose cations accordingly. The rationale for funding changes must relate directly to the target population.

treat Agenda:

suggested breaking the council into the groups from the August 18 meeting, with their assigned service categories, and having h group develop a detailed proposal to bring to the council for a vote. *GG* asked how this would work if all groups suggested a ding increase to their category. *DJ* said that *Maria Ramos*, of the Support Center, has already been asked to assign small groups ording to area of expertise. She suggested that another way to structure the small group discussion would be to create fluid groups ch would allow everyone to have input into the discussions of all the service categories. A third possibility would be to have all ups discuss the entire Prioritization Committee proposal and use it to develop a balanced budget according to a 5% funding cut. furthered that proposed changes to the Prioritization Committee's budget must be accompanied by their rationale. The committee eed on this structure for small group discussion at the retreat: ***groups will be presented with a full, balanced budget proposal and ed to propose changes to this budget, to be accompanied by the rationale for those changes.***

listed agenda items for the retreat: 1. review consensus documents 2. vote on the service category changes and priority order posed by this committee 3. present the allocation proposal, to be discussed in small groups. *JKl* suggested that Prioritization nmittee members disperse among groups to explain the allocation proposal and its rationale. *TC* raised the concern that council nbers who have not been active in the process up to this point will require extra tutoring on the origins of the proposal, which will ay the process. *DJ* said that it will be the job of the Prioritization Committee members to keep discussion moving. *TC* suggested Support Center staff facilitate the small groups, with at least one Prioritization Committee member present in each as a resource son. The committee agreed to have two people from Prioritization (including AIDS Office staff), and a Support Center staff nber attend each small group, and to allot 1 1/2 hours for small group discussion. The groups will be presented with both the posal narrative section which was presented at the August 18 full council meeting and the proposed budget to be developed at this eting (balanced to a 5% funding cut), and a vote will be held on the small groups' recommendations if consensus can not be hed. *JKl* suggested presenting a budget proposal for another funding scenario as well, unless the council wants to raise allocations oss the board in the advent of higher funding. *WC* suggested identifying areas to be augmented if CARE does not receive the 5%

ck to the Budget Proposal:

ntal **funding increase rationale:** 1. increase accessibility by expanding primary care contracts to include the dental services which offered at those same sites 2. community input has shown the need for more and better dental services.

nplimentary therapy **funding decrease rationale:** reduced utilization.

me Health **funding cut rationale:** 1. prioritize for the severest need as indicated by acuity of illness 2. reduction in demand for pice services. *JA* asked if the proposed home health cut would effect residential hospice programs. It would not. Due to hesitance ut this cut, *DJ* suggested flagging the home health subcategory as one to be restored in the advent of higher funding, to be endant upon its utilization. *TC* noted that V & H is in a labor dispute, which is effecting its utilization. *KB* said that multiply gnosed should be added to the target population for this service. *WC* asked what is the alternative to home infusion. *DJ* replied people in need of long-term infusion treatment, who do not have a home, become inpatients at Laguna Honda. She said that a cut his subcategory would be justified by its subjection to the test of severe need. Also, there are other funding streams and competing ncies. *JA* noted that this cut does not consider the fact that some people are still failing on new treatments, and more may fail in future. *DJ* suggested noting the entire Outpatient/Ambulatory Care/Dental category as one that will be greatly effected, and ire augmented funding, if new treatments prove effective for a limited amount of time, as some data suggests. *WC* noted that n if new treatments fail some people, fewer will have full-blown AIDS than before. Because the current system was built to ommodate the previous population, it should at least remain adequate, if not better than before. Thus the currently proposed $5 lion should be enough. *KB* noted that, although fewer people may require acute care at this time, there are actually more people in primary care system due to increased longevity. In addition, the issue of drug interactions is rising as a concern in the primary field. For these reasons it is unrealistic to think that the need for care is diminishing. *WC* suggested allocating $5 million to the re category, based on his assessment of the need. *KB* recommended $5.2 million, based on last year's invoiced amount. *JA* raised issue of underserved communities, and the concern that a large cut to this category would adversely effect their access. He posed cutting $2.5 million. The committee agreed to ***cut primary care by $200,000.***

raised the question of pharmaceuticals; what is included in CARE-funded pharmaceuticals and how can a needed funding change letermined? *KB* asked if Direct Emergency Financial Assistance money can be used for medications in cases where ADAP and nty money can not. *TC* replied that it can. *WC* explained that the pharmaceuticals subcategory was proposed in order to get some trol on this cost, which both *Mitch Katz*, of the AIDS Office, and *Sandra Hernandez*, formerly of the DPH, admonished the ncil to take on. The purpose was not to have the council discuss exactly what is to be covered in this subcategory. In terms of ding, the difference between *RZ*'s and *WC*'s data needs to be reconciled. Whatever the funding is, however, the committee agreed to change it, but to note a possible future change in ADAP which could necessitate a funding increase. The pharmaceuticals gory was also flagged as one to be augmented in the advent of higher CARE funding.

Food category allocation: *TC* noted that the bulk of the allocation to this category funds home delivered meals, and suggested applying an income criteria to this service to ensure that those receiving meals are the most needy. This criteria could be modeled of the HUD "low income" criteria, which is roughly $10,000 per year. *JI* noted that the amount currently allocated to the food category provides for 900 of the 4,000 people currently receiving home delivered meals in San Francisco. *WC* proposed allocating $1.5 million to the category, which would solely serve the most needy, and building up the linkages to other resources in order to augment these serves. The committee agreed to ***maintain Food category funding, but redirect it to the most needy.***

Mental Health allocation: *DJ* reminded the group that residential mental health treatment is still within this category. It is clear that the $3.8 million in this category does not adequately target the most needy. $2.5 million of the allocation goes to licensed psychotherapy, which the committee agreed is the area to cut. *TC* proposed a reduction to licensed psychotherapy and increase to crisis intervention services. *KB* noted tha crisis intervention is one of the few mental health services that is adequately provided by the city. The area that is not covered is longer-term, nor crisis care. *TC* agreed that services are available for people in the most severe crises, but said that people at the lower end of the crisis spectrum a are not served. The committee agreed that CARE should target the "sub-5150" population. *WC* suggested allocating $2.5 million to mental healt excluding residential programs. *TC* proposed divesting the entire $350,000 from Chateau Agape. These suggestions amount to a $1.5 million cu *CC* supported this cut, and specified that crisis and psych services should be held harmless at this point, and licensed psychotherapy cut $1.2 milli Severe need and access are the rationale behind this suggestion. *KB* added that, based on severe need, licensed psychotherapy should be preserve for the multiply diagnosed. *DJ* noted that the overall thought for these changes is to redirect funding toward stabilization and crisis prevention. *T* observed that this sounds like the directive of CMHS. *MM* noted that this approach does not serve those who are approaching crisis, but not there yet. *DJ* responded that this allocation is for the worst case scenario, and this category can be noted as one to restore, given greater funding, in whi case it would be possible to target more of the pre-crisis population. *WC* said that CARE should begin to work with CMHS, as the pre-crisis (i.e. pre-CMHS), provider for people with HIV. This sort of collaboration would prove more effective than mimicking CMHS' services. *JKI* further noted that mental health services need to link to primary care, substance abuse etc., rather than existing as an isolated service. *MLD* raised the issu of mental health services for youth, who are currently severely underserved. *CC* noted that youth often end up in the juvenile justice system inste of the mental health services system. The final consensus: ***cut $1.2 million from licensed psychotherapy, remove residential psych (with the thought that it will be picked up by another funding stream), hold crisis and psych consult services harmless.*** *DJ* noted that mental health servi need to be refocused on the highest need populations, crises, crisis prevention, youth and linkages to primary care. With greater funding, CARE services would be expanded outward from pre-crisis, and youth services augmented. *WC* clarified that youth should be part of the target populatio not an extra population to be served if funding is greater than expected.

KB observed that it was never clearly stated if the cuts being proposed are from the allocated or invoiced numbers from last year. She suggested starting from the invoiced numbers because that would require fewer cuts. The committee agreed that the ***proposed cuts are based on the invoice not allocated, numbers.*** DJ observed that in that case enough money has already been cut, but the qualitative decisions around redirection of funding and prioritization within categories remain to be made. For the purposes of presenting this proposal to the full council, it was decided that *WC* and *RZ* would create the numbers sheet and *TC, JKI* and *KB* would write the narrative section.

Substance Abuse allocation: *TC* noted that, according to the numbers provided by *RZ*, a large portion of the funding to this category goes to residential treatment, which has been proposed to roll into HOPWA. Thus the category may be cut by a significant amount. *DJ* asked what would happen if HOPWA did not pick up the operating costs, and noted that even if it does this category requires redirection. *JKI* noted that not all the funding which goes to residential programs actually pays operating costs. *CC* explained that operating costs are the facility itself, the utilities and insurance. This does not include staff training, salaries etc. *WC* said that if CARE does not change the configuration of this category and its relationship to others, then when CARE funding is gone its substance abuse programs will also disappear. *DJ* suggested strengthening substance abuse linkages to primary care, and incorporating new outcome measures. She further asked if the severest need is being met, to which *CC* responded that it is, but more methadone maintenance is needed. *DJ* noted that programs must allow clients to repeat treatments in order to preven their return to substance abuse, and more programs need to focus on harm reduction, rather than abstinence. *CC* recommended allocating a large sum to methadone maintenance, and a smaller amount to special populations such as women, gay men etc. *MH* commented that methadone treatment must be HIV-specific. *DJ* asked if methadone services currently have the capacity for more HIV-specific treatment. *KB* said that it will important to stress linkages between services, both to support greater HIV-specific service, and to ensure that treatment persists after CARE fundin is gone. *DJ* suggested redirecting the priority in this category to youth and multiply diagnosed, and focusing on harm reduction and linkages to primary care. *KB* proposed cutting $1.6 million from residential services on the grounds that they do not provide linkages. *DJ* observed that residential services do stabilize people by giving them food and lodging for at least a night. She proposed that if transitional substance abuse programs are to be reduced, that reduction be offset by additional funding to the housing category. *WC* said that CSAS should take on the operatin costs for residential programs while CARE continues to fund the services offered within those programs. *TC* noted that another change needs to be the development of outcome directives for substance abuse treatment programs. Regarding the possibility of CSAS taking on operating costs, *DJ* said that CSAS can't even provide treatment on demand at this time, so it can not assume a new cost. She also reminded the committee that this is be a multiphase, multiyear project, and reiterated the need to build linkages to CSAS. No final dollar amount was decided upon, but the group agreed to ***shift some amount from transitional substance abuse programs to housing, with a focus on substance abuse.***

The Mayor's HIV Health Services Planning Council meets on the third and fourth Mondays of each month, at 10 United Nations Plaza, 6th floor. The next Steering Committee meeting will be held on May 12, at 25 Van Ness Avenue. All are welcome and have the opportunity to comment on Agenda items. The site is fully accessible, and assistive hearing devices and signing are provided upon adequate future notice. Minutes of meetings and all information distributed to Council members are available for inspection and copying. For further information, contact the Council's staff, 554-9136. For requests for excused absences, Emily Coles a 777-3229. *Minutes of meetings are tentative until formally approved by the council.*